Roberge, Sandra

From:
Sent: July 22, 2017 02:18 AM
To:
Subject: 6/20 - Powder Spill, V3

Powder Spill Incident at Vancouver International Mail Centre, Tuesday, June 20, 2017
Report by Superintendent All times approximates. V3

On Duty: Chief Superintendents:

1341 hrs, a radio call was received in the superintendent's office advising of an unknown powder spill at XR-N2. BSO is assigned to this workstation. Superintendent advised would attend to assess the situation.

1351 hrs, I attended to the spill site at XR-N2. I observed BSOs and in a cordoned off area with several Canada Post employees. arrived with OHS member BSO I liaised with and Canada Post supervisors to assess the situation. advised me that there was an unknown powder on the feed belt into XR-N2, as well as inside the machine. A Canada Post employee was handling the intake but could not identify the source of the unknown powder. We were unable to locate the suspected source or parcel. We were able to establish that the mail was originating from Malaysia.

After a discussion with Canada Post, the decision was made to contact Tervita Waste Management. asked me to call them as , the Canada Post was in a meeting. I attempted to call on my BlackBerry and eventually got through to a phone service and left a message. The reception in the area was poor and kept cutting out. arrived and also called Tervita.

I was informed there was mention of a bad odour by XR-N3 immediately preceding the powder spill. This station was manned by . also complained about the odour, as well as from Canada Post. said the suspected parcel from which the odour was emanating had been secured in a mono and moved away from the immediate area.

At some point, I collected two swab samples from the intake belt to XR-N2 for the ion scanner and passed them to BSO . The time frame was not known.
Richmond Fire Department arrived and took care and control of and and I had no further involvement with them. RFD began decontamination procedures that involved and removing their contaminated clothing and belongings. Richmond HAZMAT team arrived and I liaised with Fire . The HAZMAT team tested the powder spill residue and informed me it tested negative. explained further that the residue was not a biohazard, not biological and neutral – "a good thing" in words. provided me with a small vial that held the suspected residue collected from the intake belt.
I received a phone call from EAP/CISM Coordinator Darlene ALLARD. She informed me that she was aware of the situation and would be sending representatives to VIMC soon. I provided her with a brief overview of the circumstances.
1600 hrs, Richmond HAZMAT team concluded their testing and involvement with this incident and exited the building. At this point, all others had vacated the quarantined area. I gathered up the bagged clothing and personal items of and and returned to the office. I proceeded to the bathroom and washed any exposed skin surfaces. The clothing items were secured in Exam Room "B" and the cell phones were secured in the Bond Room in the superintendent's locker #5.
and I prepared the paperwork to send the residue vial to the CBSA Laboratory in headquarters. The vial was secured in the Bond Room and shipped the next morning. I informed DEC Officer Collette KNIGHT of our intentions. Lab# D0439270, PIN# W7539717000136015.
EAP and CISM representatives Norio RENOVICH, Daphne CHIN and Robin WHITE arrived to provide assistance and services. I had a discussion with WHITE regarding the events of the day.
I met with Chief and discussed the incident and when a preliminary report was required.
1948 hrs, submitted my preliminary report to Chief .
2015 hrs, concluded my activities for the day.
June 22, 2017 - Preliminary lab results are negative for CDSA items.
July 18, 2017 – Official lab results confirm negative for CDSA items. Delay due to lab equipment failure.
End report.

Canada Border Services Agency / Agence des services frontaliers du Canada

HAZARDOUS OCCURRENCE INVESTIGATION REPORT
LAB 1070

RAPPORT D'ENQUÊTE DE SITUATION COMPORTANT DES RISQUES
LAB 1070

1. Type of occurrence/Genre de situation

- [x] Disabling injury / Blessure invalidante
- [ ] Loss of consciousness / Évanouissement
- [ ] Explosion / Fire / Explosion / Feu
- [ ] Emergency procedure / Mesures d'urgence
- [ ] Other (Specify): Autre (Préciser) :
- [x] Minor injury (with medical aid) / Blessure légère (nécessitant des soins médicaux)
- [ ] Incident (near miss /quasi situation)

2. **HRSDC use / À l'usage de RHDSC :** Department file No. / N° de dossier du ministère

HRSDC use / À l'usage de RHDSC: Regional or District Office / Bureau régional ou de district

HRSDC use / À l'usage de RHDSC : Employer ID No. / N° d'identification de l'employeur

CBSA use / À l'usage de l'ASFC : CBSA No. / N° ASFC

3. Employer's name and mailing address / Nom et adresse postale de l'employeur

CBSA
5940 FERGUSON RD.
RICHMOND BC

Postal code / Code postal: V7B 0B4

Telephone number / Numéro de téléphone

Site of hazardous occurrence / Lieu de la situation comportant des risques: CBSA X-RAY STATION #2 X RAY STATION #3

Date and time of hazardous occurrence / Date et heure de la situation comportant des risques: TUESDAY, JUNE 20 — 13:52

Weather conditions / Conditions météorologiques: NA

Witnesses / Témoins

Supervisor or manager's name / Nom du superviseur ou du gestionnaire

Supervisor or manager's signature / Signature du superviseur ou du gestionnaire

4. Description of what happened / Description des circonstances

WORKER OPERATING X-RAY #3 CLAIMED WAS EXPOSED TO A PARCEL WITH NOXIOUS ODOURS.

Brief description and estimated cost of property damage / Description sommaire et coût estimatif des dommages matériels

N/A.

5. Injured or reporting employee's name / Nom de l'employé blessé ou qui signale les circonstances

Age / Âge

Occupation / Profession: BSO

Years of experience in occupation/ Nombre d'années d'expérience dans la profession

Description of injury (if applicable) / Description de la blessure (s'il y a lieu)

Sex / Sexe

Direct cause of injury / Cause directe de la blessure: POSSIBLE EXPOSURE TO NOXIOUS ODOURS.

Was training in accident prevention given to injured employee in relation to duties performed at the time of the hazardous occurrence?
L'employé blessé a-t-il reçu une formation en prévention des accidents relativement aux fonctions qu'il exerçait au moment de la situation comportant des risques?

☑ Yes / Oui

☐ No / Non Specify / Préciser

Was this injury caused by the Use of Force (if applicable) / Est-ce que cette blessure est liée au recours à la force (si applicable) NO.

- ☐ During Control and Defensive Tactics training / Dans le cadre de la formation sur les tactiques de défense et de maîtrise
- ☐ In the course of the employee's duties / Dans le cadre des fonctions de l'employé

6.Direct causes of hazardous occurrence / Causes directes de la situation comportant des risques

POSSIBLE EXPOSURE TO NOXIOUS ODOURS, OR UNKNOWN POWDERS.

7.Corrective measures and date employer will implement / Mesures correctives qui seront appliquées par l'employeur et date de leur mise en œuvre

- WORKING ON EXISTING + NEW S.O.P.S - ONGOING.
- WORKING WITH CANADA POST JOINTLY ON SOME SOPS. ONGOING.

Reasons for not taking corrective measures / Raisons pour lesquelles aucune mesure corrective n'a été prise

AS ABOVE. ONGOING.

Supplementary preventative measures / Autres mesures de prévention

AS ABOVE. ONGOING.

8.Name of person investigating / Nom de la personne faisant l'enquête	Signa	Date
		JUNE 21, 2017
Title / Titre SUPT	Telephone number / Numéro de téléphone	

9.Work place committee's or health and safety representative's comments / Observations du comité de santé et de sécurité local ou du représentant

Work place committee member's or health and safety representative's name Nom du membre du comité local de santé et de sécurité ou du représentant	Signature	Date 02 June 17
Title / Titre BSO	Telephone Number / Numéro de téléphone	

VIMC incident that occurred on June 20, 2017 involving BSO

On June 20th, 2017 at approx. 13:45 hrs, I was working at x-ray non con 3 and BSO was working x-ray non con 2 (beside me). The type of mail I was x-raying at the time of the incident was China packet mail

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While x-raying the China packet mail I suddenly had a few parcels come through my x-ray that displayed an x-ray image that did not concern me as parcels that need further examination. When the parcel came out of the x-ray a very strong chemical smell came from one of the parcels. I tasted chemical instantly in my mouth. At first I didn't think it could have been the parcels because it was so instant. I asked my co-worker if could smell the chemical. was x-ray that was approx. four feet away, stated she could not. came closer to my x-ray and as soon as came to the exit point of my x-ray stated that she could really smell it. The Canada Post employee that was co-ordinating the x-rays stepped back as soon as smelled it but stated that could smell it as well. The that was at the take away end was talking to a Canada Post employee that was feeding the x-ray so was not exposed but as he came closer stated that could smell something as well. described it as a burning rubber smell. At this point the smell was very thick in the area and I asked the Canada Post to move the mono away because CP had a P05 (fork lift driver) pick it up and take it out of the area.

BSO returned to x-ray and at that point a Canada Post asked BSO to stop x-ray because the Canada Post employee that was loading the x-ray noticed white powder once he emptied his mail bag. By the time the x-ray was stopped the powder was inside the x-ray. It was at this point that BSO informed me that there was a powder spill. We mustered away from the area and notified the A/Supt of the incident. I could still taste the chemical from my x-ray but I started

Once the Supt's arrived BSO and I explained that the powder was contained in the x-ray.

End of Report.

Roberge, Sandra

From: Lee, ChristinaW
Sent: March 12, 2019 05:55 PM
To: Lee, ChristinaW
Subject: FW: VIMC End of Day Report - June 20, 2017 Day Shift 0800-1600

From:
Sent: June 21, 2017 3:18 PM
To: PAC-DIST_VIMC_EDR <PAC-DIST_VIMC_EDR@cbsa-asfc.gc.ca>
Subject: VIMC End of Day Report - June 20, 2017 Day Shift 0800-1600

Distribution delayed due to yesterday's powder spill incident

VIMC Operational Report - Day Shift June 20, 2017

Chief

Superintendents

Significant Enforcements, Incidents and Potential Media Attention

Statistics impacted by work stoppages due to x-ray technical issues and powder spill

SRT# S1005629 PAC 01
On June 20, 2017 at approximately 0830 – 1100 hrs PST, X-Ray Station #1 at Vancouver International Mail Centre became non-operational. Canada Post (CP) had previously installed a new takeaway conveyor belt which affected the x-ray station.

CP techs eventually resolved the electrical/circuit issues and X-Ray Station #1 is fully operational again.
X-ray down time will impact overall processing volume totals for the June 20 dayshift.

SRT# S1005642-PAC01

On June 20, 2017, at approximately 1341 hrs, a spill was reported at an X-ray machine within the Vancouver International Mail Centre.
Superintendents and the OHS rep attended to find that the affected area had been taped off to establish the quarantined area.
A risk assessment of the immediate area could not locate the suspected source or parcel which was believed to be contained in a mail bag from Malaysia.
Two Border Services Officers and five Canada Post employees were in the area at the time of the spill. Just prior to reporting the spill, the officers had encountered another parcel with a noxious odor from a mono that had been removed by Canada Post. Canada Post contacted Tervita to assist with the spill response and clean up.
Initially, the officers appeared to be suffering no visible signs of distress related to the spill.

As it was inconclusive as to whether this might be related to the presence of the noxious odor or the spill material, Emergency Services were contacted and the BC Ambulance Services, Richmond Fire Department and their HazMat team responded to the call. The superintendents and officer in the quarantine area monitored the employee's condition.
Prior to the entry of the HazMat team, two ion swabs of the material on the xray machine were non-resultant for opioids or other substances.

Subsequent testing by the hazmat team confirmed that the material was not a biohazard. A sample was taken by the hazmat team and will be forwarded to the CBSA Lab for further analysis. After initial assessment by EMS, the officers underwent a decontamination and were then transported by paramedics to Richmond General Hospital at approximately 1545 hrs. They were assessed and released from the hospital at 1908 hrs and both are reported to be doing well.
EAP and CISM services were offered to all staff and attended the operation this evening and will return in the morning.
The HazMat team concluded their testing at approximately 1630 hrs and gave the all clear to proceed with decontamination of the affected area.
Tervita attended and completed decontamination of the xray area and the officers' personal effects. Xrays 2/3 remained closed while all remediation was completed.
All other primary x-rays and secondary were fully operational by 1700 hrs. An Occupational Safety and Health walk through was completed at 2230 hrs and the area is now deemed safe.
This event is considered closed.

Operational Overview

Day Shift	
Operational BSO	
SBSO	
Total	

Enforcement Actions	
Intercepts	

Enforcement Completed	

Operational Volumes	
Primary Inventory (Mono)	
Primary Oldest Date	**May 27**
Secondary Inventory (IDC)	
Secondary Oldest Date	**May 30**

Primary Total (0800-1600)	**CP did not provide due to spill**
QA (IDC)	
Secondary (IDC)	

Staffing

Leave	
Annual Leave / CT / LWOP	**7**
Sick Leave	**0**
Family Related Leave	**0**
Other / DRSC / Training	**1**

Non- Con	
08:00 – 09:45	
10:00 – 12:00	
12:30 – 14:00	
14:15 – 16:00	
Secondary	
08:00 – 09:45	
10:00 – 12:00	
12:30 – 14:00	
14:15 – 16:00	
Roving	

08:00 – 09:45	**0**
10:00 – 12:00	**0**
12:30 – 14:00	**0**
14:15 – 16:00	**0**
Seizure Processing	
08:00 – 09:45	
10:00 – 12:00	
12:30 – 14:00	
14:15 – 16:00	

Shift Observations/Occurrences

- monos processed through Secondary X-Ray.
- CBSA and Canada Post management examined the new conveyor belts periodically throughout the day regarding any concerns.
- The starting inventory was IDCs awaiting secondary processing. The oldest mail in secondary was May 30, 2017.

- Continuing to monitor primary processing. Numbers last week have been consistently between and trending up.

Briefing

Staff briefed on new conveyer belts for X-Ray non-con #1 and #5.
Staff briefed on recent enforcement trends by MOON.
Staff reminded that PPE is readily available and must be used during examination of unknown powders/substances.
Staff reminded that all referrals to OGDs or enforcement offices must be opened and examined prior to referral.

Seizure Processing

Enforcement Document Unit (Weapons) K19	
Enforcement Document Unit (Weapons) K24	
No-Case Narcotic Seizure Unit	
All Other Enforcement - K19	
All Other Enforcement - K24	
Total Enforcement Actions Completed	

Enforcement:

Imports:

Exports:

Low Risk/Low Value Bulk Mail Released				
Mailer	Monos	Total Pieces (approx)	Total Value (approx)	Avg value per item

Canada Border Services Agency | Agence des services frontaliers du Canada

Report on the Recommendations related to June 20, 2017 Hazardous Occurrence and Investigation

Vancouver International Mail Centre

Prepared by : Colleen Pinvidic
Chief
Vancouver International Mail Centre

Hazardous Occurrence and Investigation

Vancouver International Mail Centre

Background

This provides a summary of action taken to date in response to a Workplace Hazardous Occurrence which took place on June 20, 2017 at the Vancouver International Mail Centre (VIMC). This hazardous occurrence involved the presence of a noxious smelling parcel and a coincidental spill of a small amount of unknown powder parcel at X-rays 3/2 (XR-3, XR-2) at Vancouver International Mail Centre. The potential exposure to an undetermined smell caused subsequent discomfort and/or physiological symptoms experienced by two CBSA employees.

A number of reports related to the event were received after the hazardous occurrence and offer a chronology of the events as recalled and provide sufficient detail to identify where recommendations for procedural changes or enhancements can be initiated to ensure workplace safety and to fulfill obligations to the *Canada Labour Code*. However, given that a number of individuals have not returned to the workplace, a number of clarifying points and details are not available at this time. Thus, additional comments or observations may arise a later date.

As with any hazardous occurrence investigation, the intent of the review and all aspects of the investigation are focussed on fact finding, not fault finding to improve response capacity and to further enhance procedures. The appendix to this report contains a number of recommendations that fill gaps and strengthen existing procedures with additional equipment.

This report is focussed on procedural improvements. Any issues related to Code of Conduct or Labour Relations will not be addressed in this report.

Hazardous Occurrence Overview

On June 20, 2017, at approximately 1341 hrs, a powder spill was reported at X-ray machine #3 (XR-3) within the Vancouver International Mail Centre. Two Border Services Officers (BSO) and five Canada Post (CP) employees were in the area at the time of the spill.

Superintendents and the OHS rep attended to find that the affected area had been taped off by the employees working at those stations to establish the quarantined area or "hot zone". A risk assessment of the immediate area could not locate the suspected source of the spill which was believed to be contained in a mail bag from Malaysia.

Canada Post requested that Canada Border Services Agency (CBSA) representatives at the spill site contact Tervita to assist with the spill response and clean up. Initially, the officers were observed to be suffering no visible signs of distress related to the spill.

It was later learned that just prior to reporting the spill to management, the officers had encountered another parcel with a noxious odor from a monotainer that had been presented by Canada Post and moved through the x-ray. The employees had attempted to determine which parcel had emitted the odour but could not identify a specific parcel. A Canada Post employee was asked to remove the monotainer from the immediate area.

Upon arriving at the location of the hazardous occurrence, acting superintendents attempted to conduct a scene assessment. At that time, one employee conveyed that she was experiencing physical discomfort and requested that 9-1-1 be called.

As it was inconclusive as to whether this might be related to the presence of the noxious odor or the spill material, a call was made to 9-1-1 and this information was conveyed accordingly. The emergency services response included attendance of multiple units from the British Columbia Ambulance Service, Richmond Fire Department (RFS) and their Hazardous Materials (HazMat) team and the Royal Canadian Mounted Police (RCMP). Canada Post were also in attendance both at the location of the occurrence and engaging with first responders. Due to the unknown status of the spill material and the potential risks to their staff, emergency services did not immediately enter the facility until an assessment by the HazMat responders was performed, including a recommended decontamination of symptomatic individuals who had been at the location of the spill.

The superintendents and officer in the quarantine area monitored the employee's condition until responders arrived, including heart rate and respiration. This was relayed to responders periodically until they physically attended the scene.

Prior to the entry of the HazMat team, two ion swabs of the material on the x-ray machine were tested and found to be non-resultant for opioids or other substances. This risk assessment provided sufficient feedback to allow the HazMat team them to enter the facility and to provide instruction on the degree of decontamination required to allow further assessment by Emergency Health Services (EHS).

After initial assessment by EHS, the officers were required to undergo a decontamination that was requested by EHS prior to transport. This required disrobing at the location of the spill and changing into temporary clothing, showering and changing into other temporary clothing as provided by EMS. No other

employees working in the area were subject to this protocol. There were no adverse reactions experienced by any other employees at the time.

Subsequent testing by the hazmat team confirmed that the material was not a biohazard. A sample was taken by the hazmat team and forwarded to the CBSA Lab for further analysis. The HazMat team concluded their testing at approximately 1630 hrs and gave the all clear to proceed with decontamination of the affected area. Tervita attended and completed decontamination of the XR-2 and XR-3 and the officers' personal effects.

At approximately, 1530 hrs, the employees were transported by paramedics to Richmond General Hospital. They were accompanied by a CBSA Superintendent and a BSO who had both been involved the scenarios. They were assessed and released from the hospital at 1908 hrs. They were reported to be doing well at that time.

While Tervita was called to clean up the area of the spill, they did not isolate the suspect parcel contained in the monotainer. It was verbally reported that they noticed a general 'moldy' smell within the enclosed area container that held the monotainer believed to contain the parcel with the noxious odor that was inspected later in the evening. Canada Post was asked to advise if there were any additional reports received from anyone who may have subsequently handled the parcel in the plant, at delivery or at a postal outlet. No information was relayed back.

EAP and CISM services were offered to all staff, including those assisting the affected employees directly. They attended the VIMC on June 20, 2017 and June 21, 2017.

X-rays 2/3 remained closed while all remediation was completed and an Occupational Safety and Health walk through was completed after the clean-up.

Process and Physical Environment

A brief description of the physical environment:

Process
Parcels processed at x-rays 2 and 3 are either dumped direct from mail bags or physically handled by Canada Post who move parcels from the monotainer to the intake of the respective x-ray unit. The parcels move through the x-ray and images are viewed and risk assessed by a border services officer to make a release or refer decision. Physical contact with parcels occurs when an officer views a parcel for additional information or isolates a parcel that will be referred. Parcels move through the x-ray quickly and are processed within seconds. Parcels that have been released, continue on an outtake belt and are placed in a monotainer by a Canada Post employee.

Monotainers are then removed for further processing by Canada Post and the parcels enter the domestic stream. This involves sorting and bagging for delivery both by truck or air and onwards for direct delivery to an importer or to a postal station via the domestic stream

Ventilation
X-rays 2 and 3 are situated in an open area within the Canada Post plant. The workspace has no enclosures and has ventilation that is consistent within the entire plant.

Workspace
The workspace includes the x-ray and related computers and screens for viewing and referrals, tubs containing personal protection equipment, chairs and various mail receptacles that are handled by Canada Post. Canada Post employees do not use chairs while performing their work at these stations.

The distance between the XR-2 and XR-3 is approximately eight feet.

Parcel Identification
Specific descriptions of the suspected parcel have not been confirmed. There were no details available as to the size, weight or other distinguishing characteristics of the goods in question. The parcel was not identified or isolated at the time of the hazardous occurrence. There are no details to confirm that the parcel was opened. While the monotainer was moved away from the work area, the lack of detail made it more challenging to identify the suspected parcel.

Without details to assist with the identification of the parcel, it is unlikely that anyone would reasonably be able to confirm and isolate the offending parcel without smelling each one- which contradicts safety protocols. The smell is described in reports as as "chemical", "burning rubber", "Chemical gas", "burning plastic smell". No other sources were attributed to the smell from either the work environment or equipment nearby.

Hazardous Occurrence Investigation

While the scenario unfolded on the day, management was actively assessing many aspects of the occurrence to look for processes handled well and for those where additional equipment, training or tools would be required to enhance procedures and contribute to improved safety and wellness for all employees. This included suggestions discussed or recommended by first responders at the time. This hazardous occurrence was one of the first formal tests of the recently documented spill procedures.

An initial investigation commenced immediately following the June 20, 2017 hazardous occurrence. It was signed and completed by the local Occupational Health and Safety (OHS) representative and a member of the management team on June 22, 2017. All documentation was distributed according to established procedures. The local Union asked for and was provided copies that were forwarded to the affected employees.

Reports were received from managers involved in the event over the days immediately following the incident. The two employees who were subject of the hazardous occurrence provided notes through the Union on July 18, 2017. A report from the Canada Post employee was also provided by the Customs and Immigration Union (CIU). Additional documents and recommendations were received on July 26 and August 16 from another witness. It was also requested that Canada Post secure the Closed Circuit Television footage of the area of the spill, however this footage has not been accessed by CBSA as the information contained in the reports received contained adequate detail to assess the hazardous occurrence and related recommendations.

Local management also consulted with Canada Post on the day following the hazardous occurrence to assess procedures and to determine further refinements to existing guidelines that would assist with response, communication and increased alignment between our operations. Recommendations related to this discussion are included in the appendix to this report.

Safety and Health Officers, representing the Labour Program Employment and Social Development Canada (ESDC) were in contact with management the day following the hazardous occurrence. This was in part due to the awareness created by the media coverage of the situation, and in response to a call that had been made by the local Union. ESDC requested to review reports that were available to date including the Lab 1070's, the published spill procedures and notes from those involved. Subsequently, they requested a meeting with a member of management and a representative of the Occupational Health and Safety (OHS) Committee which took place on July 11, 2017. The meeting was attended by two members each representing management, the OHS Committee, and ESDC.

ESDC reviewed the scenario, the notes and the procedures and participated in an inspection of the location where the incident occurred. They confirmed that the procedures and framework were followed for the spill. While the formal documentation had been recently finalized, the procedures had been discussed by the OHS committee and had been practiced for some time. ESDC could not further assess or provide recommendations with respect to the suspected noxious parcel as the parcel was not identified and was no longer present. Management also discussed a number of the issues and actions that were planned, most of which are included in the attached table and ESDC confirmed that these items would form the basis of the final report. This table has also been shared with the local Occupational Safety and Health Committee and formally with ESDC.

There have been a number of consultations and resources since that hazardous occurrence that offer new options to consider for safe handling procedures. A webinar entitled, "***Fentanyl: Health Risks and Exposure Prevention***" was offered by the Canada School of the Public Service on July 14, 2017, and provides new insight into the science and properties of fentanyl and will help to inform both the local and national approach to responding and reporting of spills moving forward.

Discussions pertaining to some aspects of this investigation were also discussed during a regional visit of the National Opioid Working Group who visited the VIMC on July 18 and 19, 2017. The participants at this event included national representatives from the Customs and Immigration Union (CIU), Operations and Programs Branches and national OHS. In addition, speakers included a number of guests representing TacMed, ESDC, Health Canada, RCMP and local management and union representatives who lent expertise and experience to better inform the discussion and some of the issues related to this hazardous occurrence.

On June 21, 2017, the Union forwarded a complaint under Section 127 (1) of the *Canada Labour Code (CLC)* alleging that CBSA had not appointed a qualified investigator to carry out the investigation hazardous occurrences. The complaint also stated that, "the officers at the Vancouver International Mail Center are not qualified experts, nor should they be relied upon to find resolution to the ongoing hazardous situations occurring almost daily". After discussing this further with the Union in an ad hoc meeting held on June 26, 2017, the Union agreed that the complaint had been premature. However, it remained unclear at that time as to the level of engagement in the follow up and recommendations that the Union or the Occupational Safety and Health (OSH) were intending to provide.

To ensure compliance and respect the requirement to investigate without delay, management proceeded with consultations with professionals and acquisition of some equipment that had been discussed or suggested at employee briefings. Representatives of the local OHS committee participated in the review conducted by ESDC on July 11, 2017 and were involved in a number of informal discussions over the month following. Recommendations stemming from the hazardous occurrence were formally reviewed at the monthly OHS meeting held on August 17, 2017. Recommendations were endorsed and adopted.

Considerations

The coincidental events of a spill and presence of an undetermined noxious odor emitting from parcel within the same work area created challenges for response on the day the hazardous occurrence took place. While the recent emphasis on spill response has focused considerably on spills of unknown powders, this situation highlights the need for each scenario to be evaluated within the context of existing procedures and training in order to assess the best action. It is impossible to anticipate and document specific procedures for every potential scenario but the effort expended in dialogue, discussions and consultation has resulted in considerable enhancements to the already robust safety procedures implemented at the VIMC and this review will further develop safety and procedural protocols.

This investigation also highlights and confirms that officers within the VIMC have training, experience and procedures in place to both assess and to respond to most situations and the capacity to adapt procedures according to the specific dynamics presented during these scenarios. Key elements are continued applying training (e.g. TacMed), communication, and tools. Over time further refinement of these procedures should yield more adaptive procedures while respecting officer safety and goods processing.

Scene Survey

Due to the potential of contamination during a spill, Emergency Services will not enter a workspace to administer treatment if they believe that there is a likelihood that an individual has been exposed or come in direct contact with an unknown powder. They will enter once individuals are decontaminated to the extent that they believe is appropriate to the risk. While disconcerting, this is consistent with the response in multiple jurisdictions/agencies. Therefore, it is essential that an initial assessment be conducted to accurately assess the environment and to communicate this information through to EHS.

All uniformed staff in the Pacific Region are required to participate in TacMed training which incorporates an advanced level of tactical response with first aid. A key element in TacMed the completion of a scene survey by anyone attending the scene of a potential hazardous occurrence or other critical. This includes assessing and/or controlling the hazards, determining what happened and how injuries occurred and provides an assessment to adequately observe the situation and to assess the appropriate response plan. The survey will also provide critical data to inform any subsequent communication with any emergency responders to support their response.

A full assessment should be performed quickly to assess the situation, the response (e.g. first aid, interventions, 9-1-1) prior to ensure a strong and informed relay of information prior to calling any 9-1-1 or any additional internal or external resources for assistance. This assessment need not be lengthy, but the extra seconds or minutes may influence the response plan and better inform any response team that may be required. Anyone receiving assistance and assessment should attempt to cooperate with the requests and to assist with the assessment conducted to ensure the best and most efficient assistance is accessed.

Further, more detailed description of the scale and scope of spills may assist in conveying the scene survey and the detail relayed emergency responders to assist with their risk assessment and

determination of when it is safe to attend the facility and the priority response required. It may also determine likelihood of direct contact or exposure and whether an employee can be removed from the hot/quarantine zone to access medical treatment sooner if required.

First Aid/Training

Since the hazardous occurrence, a number of consultations and discussions have occurred with various confirmed that CBSA employees do have adequate tools and training to respond to the majority of situations but there has to be a willingness to access this knowledge. All Border Services Officers are required to take TacMed training and recertify every three years. This approach strongly emphasizes the importance of a scene survey and ongoing communication in any situation as was addressed earlier in this report. Active participation and discussion is required by all employees to ensure understanding of processes and procedures. While management is responsible to provide tools and training to the extent that is reasonable, all employees including management are responsible to apply the learning, tools, and skills to their work and to potential hazardous occurrences as they occur.

Unless direct contact with or exposure to a powder is a strong likelihood, an employee experiencing discomfort or other symptoms should advise a manager immediately as per the per Enforcement Manual (EN) Part 4, Chapter 4. Communication and consultation will determine whether the employee should remain within a quarantine area and any required first aid or other medical attention.

Once EMS attends the facility, they take the lead in managing the scene. The direction and manner to decontaminate is subject to their protocols at this point and will change based on the circumstances and the direction that they provide.

CBSA consulted with EMS to consider options to accelerate the decontamination process in future. EMS advised that this process can be initiated at any point prior to their arrival. The level of decontamination will vary according to the degree of direct contact or exposure.

To support this, the acquisition of equipment to support decontamination procedures has been completed:

- Privacy shower rod for decontamination shower to afford privacy to anyone required to fully disrobe and decontaminate;
- Privacy screen which can be wheeled to the perimeter of the containment zone for use by employees who may be required to disrobe;
- "Go Bags" for the Superintendent's Office with basic PPE, water, NarCan;
- Emergency Blankets;
- Temporary Clothing Kits;
- Portable rinse kits/showers to deploy to containment areas to perform initial decontamination.

Communication

CBSA employees have the tactical and operational training and experience to be able to respond to most hazardous occurrences. The critical element to integrate this training into practice is communication.

Effective dialogue during an event will support strong scene surveys and relaying the most accurate information to first responders. The ability to access collective learning and adapt procedures within a dynamic environment will maximize the safety of all employees which is foremost in the minds of those responding. Communication and consultation will also determine whether the employee should remain within a quarantine area and any required first aid or other medical attention.

While scenes of hazardous occurrence can become tense, everyone involved should attempt to communicate professionally and purposefully to ensure that the accurate information is gathered and shared with management and first responders as required.

Ongoing collaboration with Canada Post will continue as we endeavour to more closely align our mutual processes for handling of spills and other emergency events. The parcel believed to have emanate the odor was neither identified at the time nor successfully isolated and was one of numerous parcels placed in a monotainer that was eventually released for domestic sorting and delivery by Canada Post. CBSA has requested that stronger action is required from CP assist to ensure that any parcel that has caused some physical symptoms is diverted from the released/domestic stream until a full assessment can be completed.

Conclusion

The key recommendations are attached as an Appendix (A) to this report and include a broad scale of recommendations that will allow the operation to further refine procedures. As noted previously, these recommendations focus on procedural improvements, including equipment and training and integrate the points discussed above.

The hazardous occurrence of June 20, 2017, accentuated many opportunities to delve further into situations and common challenges that can be faced by an operation. However, the incident also demonstrated that employees have a strong skills, experience and training that can continue to be applied and adapted to changing the dynamics within the VIMC environment. The priority of the management team and local OHS continues to be the health and safety of all employees respecting the work description and other organizational restrictions. We will continue to build on the strong work that has been put in place evolve processes and procedures to a high level.

Appendix A

RECOMMENDATIONS

FINAL- October 15, 2017

Observation/Issue	Recommendation	Status
EQUIPMENT		
Personal Protection Equipment, including various styles of gloves have been made available but are not consistently worn by all employees.	Employees were reminded that gloves should be worn at primary.	This matter continues to be emphasized at shift briefings. Future situations may be subject to review and discipline.
Radio Use	Ensure that all radios are set to the same channels at the beginning of each shift.	Completed and updated at briefings.
COMMUNICATION		
Emergency contact information should be up to date for all employees	Personally update current information in CAS.	Raised at shift briefings following hazardous occurrence.
Employees should advise superintendent when feeling unwell.	Employees have been reminded in shift briefings that if they are feeling 'unwell', they should contact a superintendent immediately. Depending on the circumstances, they may either wait or remove themselves from the work station as deemed appropriate. This will be a significant factor in a scene assessment to determine the likelihood of direct exposure and/or contact with suspected Highly Toxic Substances (HTS).	Employee briefings completed.
More detailed description of the scale and scope of spills may assist in conveying the scene survey and the detail relayed emergency responders to assist with their risk assessment and determination of when it is safe to attend the facility and the priority response required.	A quick reference list incorporated in the procedures may assist and include descriptions/considerations such as: o Type of spill? (Powder, liquid, other properties) o Is it localized, contained, on a belt, on the floor? o Has the individual had any opportunity for direct contact with the commodity? o Are there any particles likely to have been airborne? o What is the distance from the employee to the spill? o Has it been sprayed or covered to minimize containment?	If there is a potential of exposure, BC Ambulance Service now offers a service where a caller can be dispatched to a paramedic specially trained for Haz Mat assessment, who may be able to provide additional direction to assist with decontamination and management within the spill area.
Communication on the floor will assist in maintaining a safe and contained environment for affected employees and to ensure that access is kept clear for first responders.	Use of Canada Post public address system will assist in notifying employees of both operations to remain clear of specific areas and to provide any further direction required.	Numbers and access to be confirmed.
Poor cellular reception in the plant was challenging and all management team faced numerous dropped calls.	An exemption will be sought to align the provider with Canada Post who has a booster to ensure consistent service throughout the facility.	An exemption has been approved to switch to Bell. This migration will be confirmed by IT.

PROCEDURES		
Due to the potential of contamination during a spill, Emergency Services will not enter a workspace to administer treatment if they believe that there is a likelihood that an individual has been exposed or come in direct contact with an unknown powder. They will enter once individuals who are suspected to have been contaminated are decontaminated. While disconcerting, this is consistent with the response in multiple jurisdictions.	○ Assisting personnel can monitor work area to prevent further contamination and clear a path to area where decontamination can safely occur. ○ Procedures will be created to initiate decontamination prior to arrival of EMS which may accelerate response and will be dependent on the degree of exposure or contact. Full decontamination may not be necessary to access employees. ○ Communication is a key element in relaying the extent and likelihood of exposure.	Procedures are currently under review for discussion by local Occupational Safety and Health Committee.
Once EMS attends the facility, they take the lead in managing the scene. The direction and manner to decontaminate is subject to their protocols at this point and will change based on the circumstances and the direction that they provide.	Incorporate this protocol into existing decontamination procedures to ensure officers are aware.	Procedures are currently under review for discussion by local Occupational Safety and Health Committee.
CBSA consulted with EMS to consider options to accelerate the decontamination process in future. EMS advised that this process can be initiated at any point prior to their arrival.	To support this, the following equipment was procured: • Privacy shower rod for decontamination shower to afford privacy to anyone required to fully disrobe and decontaminate; • Privacy screen which can be wheeled to the perimeter of the containment zone for use by employees who may be required to disrobe; • Go Bags for the Superintendent's Office with basic PPE, water, NarCan • Emergency Blankets • Temporary Clothing Kits • Portable rinse kits/showers to deploy to containment areas to perform initial decontamination.	Acquisition Complete Procedures are currently under review for discussion by local Occupational Safety and Health Committee. Final placement of equipment to be confirmed by OHS.
Clear communication is a necessity during any spill, medical event or other critical event occurs- including affected employee to on-site	Completion of an initial scene survey is necessary to convey details to first responders. As an example, attached are a number of details asked during a recent 9-1-1 call: ○ What happened?	Incorporate these details into emergency response procedures. Procedures should be further refined as required after a debrief of

contact and then on to EMS if required for the situation.	○ Male or female? ○ How old? ○ Was NARCAN used? ○ Was he/she breathing? ○ What are his/her symptoms?. ○ Is he/she alert? ○ Can he/she walk? ○ Was his/her heart beating fast?	any emergency, spill or hazardous occurrence. Laminated cards will be provided to officers and contained in all spill kits at X-ray stations.
Deployment of emergency services to the site.	Contact to the CP Control Room may assist in the deployment of arriving emergency equipment after a 9-1-1 call.	In place and tested.
Isolation of hazardous goods	Request to CP to ensure that every effort is made to isolate and secure a parcel of interest until initial investigation can occur.	Discussed and agreed to on June 21,2017. May require involvement of CP Security upon entering domestic stream.
Containment areas	Review of hot zones at each station to ensure greater consistency. Consideration will be given to scale and scope of spills and the degree to which the spill can be contained without requiring quarantine of numerous individuals or an area unnecessarily large.	Procedures are currently under review for discussion by local Occupational Safety and Health Committee.
TRAINING AND RESOURCES		
During an assessment, the symptoms and presentation should be considered prior to administering first aid, including NarCan.	The symptoms of an opioid overdose should be reviewed.	Posters have been put up throughout the facility. NarCan training has been provided to all employees to ensure awareness and recognition..
Training	All employees are required to complete the following courses • Naloxone Nasal Spray Administration (S7174-P); • Workplace Hazardous Materials Information System (H3003-P); • Transportation of Dangerous Goods (S7017-P); • All Hazards Approach E-Reference (S7075-P); and • Respiratory Protection Program (H3044-P).	Confirmation is required for all employees by September 19, 2017
Resources	Pacific Region Synthetic Opioids Wiki Page Canada School of the Public Service Webinar: ***Fentanyl: Health Risks and Exposure Prevention***	All employees should be aware of these resources and access to enhance knowledge

All employees must access their TacMed training to ensure complete a scene survey to determine the best response plan for the situation.	Scenario based walkthroughs of general emergency procedures will continue to be delivered to build on the required TacMed training and review of spill procedures	Ongoing –with further updates upon amended procedures All superintendents and OHS members have been encouraged to take the lead in these walkthroughs to encourage more discussion and learning.

Canada Border Services Agency / Agence des services frontaliers du Canada

HAZARDOUS OCCURRENCE INVESTIGATION REPORT
LAB 1070

RAPPORT D'ENQUÊTE DE SITUATION COMPORTANT DES RISQUES
LAB 1070

1. Type of occurrence/Genre de situation

- ☒ Disabling injury / Blessure invalidante
- ☐ Loss of consciousness / Évanouissement
- ☐ Explosion / Fire / Explosion / Feu
- ☐ Emergency procedure / Mesures d'urgence
- ☐ Other (Specify): Autre (Préciser) :
- ☑ Minor injury (with medical aid) / Blessure légère (nécessitant des soins médicaux)
- ☐ Incident (near miss /quasi situation)

2. **HRSDC use / À l'usage de RHDSC :** Department file No. / N° de dossier du ministère

HRSDC use / À l'usage de RHDSC: Regional or District Office / Bureau régional ou de district

HRSDC use / À l'usage de RHDSC : Employer ID No. / N° d'identification de l'employeur

CBSA use / À l'usage de l'ASFC : CBSA No. / N° ASFC

3. Employer's name and mailing address / Nom et adresse postale de l'employeur

CBSA
300-5140 Ferguson
Richmond, BC

Postal code / Code postal: V7B 0B4

Telephone number / Numéro de téléphone

Site of hazardous occurrence / Lieu de la situation comportant des risques: CBSA X-ray stn #2 X ray stn #3

Date and time of hazardous occurrence / Date et heure de la situation comportant des risques: June 20, 2017 13:41

Weather conditions / Conditions météorologiques: N/A

Witnesses / Témoins

Supervisor or manager's name / Nom du superviseur ou du gestionnaire

Supervisor or manager's signature / Signature du superviseur ou du gestionnaire

4. Description of what happened / Description des circonstances

While operating X-ray #2 worker was exposed to noxious odors from parcel at X-ray #3 - Worker walked to adjacent station (X-ray 3) to assist operator there & smelled the odor as well. When worker returned to her stn #2 a postal employee informed her that they was powder on feeding belt. X-ray was stopped there by worker.

Brief description and estimated cost of property damage / Description sommaire et coût estimatif des dommages matériels: N/A

5. Injured or reporting employee's name / Nom de l'employé blessé ou qui signale les circonstances

Age / Âge

Occupation / Profession: BSO

Years of experience in occupation/ Nombre d'années d'expérience dans la profession

Description of injury (if applicable) / Description de la blessure (s'il y a lieu): Worker expressed exposure to noxious odor

Sex / Sexe

Direct cause of injury / Cause directe de la blessure: possible exposure to noxious odor

Was training in accident prevention given to injured employee in relation to duties performed at the time of the hazardous occurrence?
L'employé blessé a-t-il reçu une formation en prévention des accidents relativement aux fonctions qu'il exerçait au moment de la situation comportant des risques?

☑ Yes / Oui

☐ No / Non Specify / Préciser

Was this injury caused by the Use of Force (if applicable) / Est-ce que cette blessure est liée au recours à la force (si applicable) No

- ☐ During Control and Defensive Tactics training / Dans le cadre de la formation sur les tactiques de défense et de maîtrise
- ☐ In the course of the employee's duties / Dans le cadre des fonctions de l'employé

6.Direct causes of hazardous occurrence / Causes directes de la situation comportant des risques

Possible exposure to noxious odor

7.Corrective measures and date employer will implement / Mesures correctives qui seront appliquées par l'employeur et date de leur mise en œuvre

Updating SOPs to keep current - ongoing -
Input from Canada Post for SOPs in coordination w/CBSA

Reasons for not taking corrective measures / Raisons pour lesquelles aucune mesure corrective n'a été prise

Ongoing

Supplementary preventative measures / Autres mesures de prévention

Ongoing

8.Name of person investigating / Nom de la personne faisant l'enquête	Signature	Date
		June 22, 2017
Title / Titre: Supt	Telephone number / Numéro de téléphone	

9.Work place committee's or health and safety representative's comments / Observations du comité de santé et de sécurité local ou du représentant

the symptoms were as a direct result of exposure to noxious vapours in a parcel.

Work place committee member's or health and safety representative's name Nom du membre du comité local de santé et de sécurité ou du représentant	Signature	Date
		22 June 17
Title / Titre: BSO	Telephone Number / Numéro de téléphone	

Report of

On June 20, 2017 I, Border Services Officer (BSO) was scheduled to work on X-ray #2 at VIMC, for the duration of the block after lunch from 1230-1400. My partner at x-ray #3 was BSO At approximately 1345 while carrying out our duties, BSO noticed a noxious smell coming from her work station. asked if I also smelled it, which while at my work station, I did not. I turned my x-ray off and went over work station, at which time I did smell the noxious smell. We investigated to determine where the smell was coming from and it was determined that it was coming from a package that was in the, CBSA released, parcels mono. One of the Canada Post employees then had a forklift driver remove that mono due to its noxious smell. After this I resumed my duty at x-ray 2. Within approximately a minute or two, one of the Canada Post Team who was at the feeding end of x-ray #2, yelled out that there was a powder spill. I immediately backed away from my work station and told all adjacent staff, including my partner BSO to step away from the area. I then notified a Supt (don't recall which one responded) via radio that there was a powder spill at x-ray #2.

CBSA Supt's along with BSO arrived next

Once we got outside the building and close to the sidewalk curb, EMS finally took over and began providing us with medical services.

BSO was taken in a separate ambulance, and Supt accompanied BSO accompanied me in my ambulance.

Once back at VIMC, CISM was still on site and figured out that I was one of the officers involved and wanted to talk to me.

Chief also spoke to me

END OF REPORT.

Roberge, Sandra

From:
Sent: June 20, 2017 10:48 PM
To:
Cc:
Subject: Powder Spill - June 20, 2017
Attachments: Powder Spill Incident at Vancouver International Mail Centre.docx

Powder Spill Incident at Vancouver International Mail Centre, Tuesday, June 20, 2017
Report by A/Superintendent . All times approximates.

Chief on duty:
Superintendents on duty:

1341 hrs, radio call received in superintendent's office. BSO at XR-N2 reports a powder spill in their area. advised she will attend to assess the situation.

1351 hrs, I attended to the spill site at XR-N2. I observed BSOs and in a cordoned off area with some Canada Post employees. arrived with OHS member I liaised with and Canada Post supervisors and to assess the situation. and possibly others, advised me that there was an unknown powder on the feed belt into XR-N2, as well as inside the machine. We were unable to locate the suspected source or parcel. We were able to determine that the mail was originating from Malaysia. After a discussion with Canada Post, the decision was made to contact Tervita Waste Management. asked me to call them as the Canada Post manager was in a meeting. I attempted to do and eventually got through to a phone service and left a message but the reception in the area was poor and kept cutting out. arrived and also called Tervita.

There was mention of a bad odour by XR-N3 immediately preceding the powder spill. This station was manned by . also complained about the odour.

Richmond Fire Department arrived and took care and control of and and I had no further involvement with them. Richmond HAZMAT team arrived and I liaised with Fire Captain I The HAZMAT team tested

the powder spill residue and informed me it tested negative. explained further that the residue was not a biohazard, not biological and neutral – "a good thing" in his words.

1600 hrs, Richmond HAZMAT team concluded their testing and involvement with this incident and exited the building. At this point, I gathered up some items from the incident and returned to the office. End.

A/Superintendent, Vancouver International Mail Centre, Operations Branch
Canada Border Services Agency / Government of Canada

A/Surintendant, Centre du courrier International de Vancouver, Direction générale des opérations
Agence des services frontaliers du Canada / Gouvernement du Canada